



**Senate Bill No. 1002**

**Public Act No. 05-94**

**AN ACT CONCERNING APPEALS OF HEALTH INSURANCE  
DETERMINATIONS MADE TO THE INSURANCE COMMISSIONER.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subdivision (1) of subsection (a) of section 38a-226c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(1) Each utilization review company shall maintain and make available procedures for providing notification of its determinations regarding certification in accordance with the following:

(A) Notification of any prospective determination by the utilization review company shall be mailed or otherwise communicated to the provider of record or the enrollee or other appropriate individual within two business days of the receipt of all information necessary to complete the review, provided any determination not to certify an admission, service, procedure or extension of stay shall be in writing. After a prospective determination that authorizes an admission, service, procedure or extension of stay has been communicated to the appropriate individual, based on accurate information from the provider, the utilization review company may not reverse such determination if such admission, service, procedure or extension of

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stay has taken place in reliance on such determination.

(B) Notification of a concurrent determination shall be mailed or otherwise communicated to the provider of record within two business days of receipt of all information necessary to complete the review or, provided all information necessary to perform the review has been received, prior to the end of the current certified period and provided any determination not to certify an admission, service, procedure or extension of stay shall be in writing.

(C) The utilization review company shall not make a determination not to certify based on incomplete information unless it has clearly indicated, in writing, to the provider of record or the enrollee all the information that is needed to make such determination.

(D) Notwithstanding subparagraphs (A) to (C), inclusive, of this subdivision, the utilization review company may give authorization orally, electronically or communicated other than in writing. If the determination is an approval for a request, the company shall provide a confirmation number corresponding to the authorization.

(E) [Any] Except as provided in subparagraph (F) of this subdivision with respect to a final notice, each notice of a determination not to certify an admission, service, procedure or extension of stay shall include in writing (i) the principal reasons for the determination, (ii) the procedures to initiate an appeal of the determination or the name and telephone number of the person to contact with regard to an appeal pursuant to the provisions of this section, and (iii) the procedure to appeal to the commissioner pursuant to section 38a-478n, as amended by this act.

(F) Each notice of a final determination not to certify an admission, service, procedure or extension of stay shall include in writing (i) the principal reasons for the determination, (ii) a statement that all internal

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appeal mechanisms have been exhausted, and (iii) a copy of the application and procedures prescribed by the commissioner for filing an appeal to the commissioner pursuant to section 38a-478n, as amended by this act.

Sec. 2. Section 38a-478m of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) Each managed care organization or health insurer, as defined in section 38a-478n, as amended by this act, shall establish and maintain an internal grievance procedure to assure that enrollees, as defined in section 38a-478n, as amended by this act, may seek a review of any grievance that may arise from a managed care organization's or health insurer's action or inaction, other than action or inaction based on utilization review, and obtain a timely resolution of any such grievance. Such grievance procedure shall comply with the following requirements:

(1) Enrollees shall be informed of the grievance procedure at the time of initial enrollment and at not less than annual intervals thereafter, which notification may be met by inclusion in an enrollment agreement or update. Enrollees shall also be informed of the grievance procedure when a decision has been made not to certify an admission, service or extension of stay.

(2) Notices to enrollees describing the grievance procedure shall explain: (A) The process for filing a grievance with the managed care organization or health insurer, which may be communicated orally, electronically or in writing; (B) that the enrollee, or a person acting on behalf of an enrollee, including the enrollee's health care provider, may make a request for review of a grievance; and (C) the time periods within which the managed care organization or health insurer must resolve the grievance.

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(3) Each managed care organization and health insurer shall notify its enrollee in writing in cases where an appeal to reverse a denial of a claim based on medical necessity is unsuccessful. Each notice of a final denial of a claim based on medical necessity shall include (A) a written statement that all internal appeal mechanisms have been exhausted, and (B) a copy of the application and procedures prescribed by the commissioner for filing an appeal to the commissioner pursuant to section 38a-478n, as amended by this act.

(b) All reviews conducted under this section shall be resolved not later than sixty days from the date the enrollee commences the complaint, unless an extension is requested by the enrollee.

Sec. 3. Section 38a-478n of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) Any enrollee, or any provider acting on behalf of an enrollee with the enrollee's consent, who has exhausted the internal mechanisms provided by a managed care organization, health insurer or utilization review company to appeal the denial of a claim based on medical necessity or a determination not to certify an admission, service, procedure or extension of stay, regardless of whether such determination was made before, during or after the admission, service, procedure or extension of stay, may appeal such denial or determination to the commissioner. As used in this section and section 38a-478m, as amended by this act, "health insurer" means any entity, other than a managed care organization, which delivers, issues for delivery, renews or amends an individual or group health plan in this state, "health plan" means a plan of health insurance providing coverage of the type specified in subdivision (1), (2), (4), (10), (11), (12) and (13) of section 38a-469, but does not include a managed care plan offered by a managed care organization, and "enrollee" means a person who has contracted for or who participates in a managed care plan or health plan for himself or his eligible dependents.

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(b) (1) To appeal a denial or determination pursuant to this section an enrollee or any provider acting on behalf of an enrollee shall, not later than thirty days after receiving final written notice of the denial or determination from the enrollee's managed care organization, health insurer or utilization review company, file a written request with the commissioner. The appeal shall be on forms prescribed by the commissioner and shall include the filing fee set forth in subdivision (2) of this subsection and a general release executed by the enrollee for all medical records pertinent to the appeal. The managed care organization, health insurer or utilization review company named in the appeal shall also pay to the commissioner the filing fee set forth in subdivision (2) of this subsection.

(2) The filing fee shall be twenty-five dollars and shall be deposited in the Insurance Fund established in section 38a-52a. If the commissioner finds that an enrollee is indigent or unable to pay the fee, the commissioner shall waive the enrollee's fee. The commissioner shall refund any paid filing fee to (A) the managed care organization, health insurer or utilization review company if the appeal is not accepted for full review, or (B) the prevailing party upon completion of a full review pursuant to this section.

(3) Upon receipt of the appeal together with the executed release and appropriate fee, the commissioner shall assign the appeal for review to an entity as defined in subsection (c) of this section.

(4) Upon receipt of the request for appeal from the commissioner, the entity conducting the appeal shall conduct a preliminary review of the appeal and accept the appeal if such entity determines: (A) The individual was or is an enrollee of the managed care organization or health insurer; (B) the benefit or service that is the subject of the complaint or appeal reasonably appears to be a covered service, benefit or service under the agreement provided by contract to the enrollee; (C) the enrollee has exhausted all internal appeal mechanisms

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provided; (D) the enrollee has provided all information required by the commissioner to make a preliminary determination including the appeal form, a copy of the final decision of denial and a fully-executed release to obtain any necessary medical records from the managed care organization or health insurer and any other relevant provider.

(5) Upon completion of the preliminary review, the entity conducting such review shall immediately notify the member or provider, as applicable, in writing as to whether the appeal has been accepted for full review and, if not so accepted, the reasons why the appeal was not accepted for full review.

(6) If accepted for full review, the entity shall conduct such review in accordance with the regulations adopted by the commissioner, after consultation with the Commissioner of Public Health, in accordance with the provisions of chapter 54.

(c) To provide for such appeal the Insurance Commissioner, after consultation with the Commissioner of Public Health, shall engage impartial health entities to provide for medical review under the provisions of this section. Such review entities shall include (1) medical peer review organizations, (2) independent utilization review companies, provided any such organizations or companies are not related to or associated with any managed care organization or health insurer, and (3) nationally recognized health experts or institutions approved by the commissioner.

(d) (1) Not later than five business days after receiving a written request from the commissioner, enrollee or any provider acting on behalf of an enrollee with the enrollee's consent, a managed care organization or health insurer whose enrollee is the subject of an appeal shall provide to the commissioner, enrollee or any provider acting on behalf of an enrollee with the enrollee's consent, written verification of whether the enrollee's [managed care] plan is fully

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insured, self-funded, or otherwise funded. If the plan is a fully insured plan [or a self-insured governmental plan,] the managed care organization or health insurer shall send: (A) Written certification to the commissioner or reviewing entity, as determined by the commissioner, that the benefit or service subject to the appeal is a covered benefit or service; (B) a copy of the entire policy or contract between the enrollee and the managed care organization or health insurer; [ except that with respect to a self-insured governmental plan, (i) the managed care organization shall notify the plan sponsor, and (ii) the plan sponsor shall send, or require the managed care organization to send, such copy;] or (C) written certification that the policy or contract is accessible to the review entity electronically and clear and simple instructions on how to electronically access the policy or contract.

(2) Failure of the managed care organization or health insurer to provide information [or notify the plan sponsor] in accordance with subdivision (1) of this subsection within said five-business-day period or before the expiration of the thirty-day period for appeals set forth in subdivision (1) of subsection (b) of this section, whichever is later as determined by the commissioner, shall (A) create a presumption on the review entity, solely for purposes of accepting an appeal and conducting the review pursuant to subdivision (4) of subsection (b) of this section, that the benefit or service is a covered benefit under the applicable policy or contract, except that such presumption shall not be construed as creating or authorizing benefits or services in excess of those that are provided for in the enrollee's policy or contract, and (B) entitle the commissioner to require the managed care organization or health insurer from whom the enrollee is appealing a medical necessity determination to reimburse the department for the expenses related to the appeal, including, but not limited to, expenses incurred by the review entity.

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(e) The commissioner shall accept the decision of the review entity and the decision of the commissioner shall be binding.

(f) Not later than January 1, 2000, the Insurance Commissioner shall develop a comprehensive public education outreach program to educate health insurance consumers of the existence of the appeals procedure established in this section. The program shall maximize public information concerning the appeals procedure and shall include, but not be limited to: (1) The dissemination of information through mass media, interactive approaches and written materials; (2) involvement of community-based organizations in developing messages and in devising and implementing education strategies; and (3) periodic evaluations of the effectiveness of educational efforts. The Managed Care Ombudsman shall coordinate the outreach program and oversee the education process.

Sec. 4. Section 38a-478s of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) Nothing in sections 38a-478 to 38a-478o, inclusive, as amended by this act, shall be construed to apply to the arrangements [of managed care organizations] offered to individuals covered under self-insured [employee welfare benefit plans established pursuant to the federal Employee Retirement Income Security Act of 1974] health plans.

(b) The provisions of sections 38a-478 to 38a-478o, inclusive, as amended by this act, shall not apply to any plan that provides for the financing or delivery of health care services solely for the purposes of workers' compensation benefits pursuant to chapter 568.

Sec. 5. Subdivision (5) of section 38a-478 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

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(5) ["Enrollee"] Except as provided in sections 38a-478m and 38a-478n, as amended by this act, "enrollee" means a person who has contracted for or who participates in a managed care plan for himself or his eligible dependents.

Approved June 7, 2005